HALL Periodontics & Dental Implants

Today's Date: _____
Mr. Mrs. Ms. Dr.
Name: _____Spouse's Name: _____
Address: _____City _____Zip _____
Phone # _____Work Phone # _____
Birth Date: _____Cell Phone # _____
Employer: _____Social Security# _____

Primary Dental Insurance Co.: _____
Insured Subscribers Name: _____Birth date: _____
SS # or ID #:_____Employer: (EVEN IF RETIRED)_____
Second Dental Insurance Co.: _____
Insured Subscribers Name: _____Birth date: _____
SS # or ID #:_____Employer: _____
I authorize this office to act as my agent in helping me obtain payment from my dental insurance company(s), and understand that any co-pay is due the day of service. I also understand that medical insurance is not billed in this office.

Signature : _____

1. **Date of last professional cleaning: _____**
2. **Frequency of professional cleanings? : _____**
3. **Do you smoke? Yes/No… Or Chew? Yes/No**
   Have you smoked in the past? _____ Number of years? : _____ How much? : _____
4. **Is it difficult for you to open your mouth as wide as you would like? Yes___No___**
5. **Does your jaw click when you chew? ---------- Yes___No___**
6. **Do you clench or grind your teeth? ---------- Yes___No___**
7. **Have you ever had gum surgery? ---------- Yes___No___**

1.Please list all surgeries that you have had in the last 5 years:

_____
_____
_____
_____
_____

2. List medication allergies or meds you can't take:

_____
_____

3. Please list all current medications and dosages, including herbal supplements:

_____
_____
_____
_____
_____

4. **Preferred Pharmacy**_____

Do you have or have you ever been told you had the following?
Please CIRCLE any of those conditions.

Heart Disease
Alcoholism
Bleeding Disorders
Diabetes
Asthma
Liver Disease or Hepatitis
Epilepsy or Seizures
Glaucoma
TMJ Dysfunction (popping jaw joints)
Joint Replacement
Are you Pregnant? Due Date: _____

Angina or Chest Pain
High Blood Pressure
Anemia
Bisphosphonate Therapy
Thyroid Problems
Emphysema
Kidney Disease
Immune Problems or HIV
Stomach Problems or Ulcers
Cancer _____

Patient Signature: **Physicians Name:**